Senate Commerce and Labor Committee 1

Amendment No. 1 to SB0839

Johnson
Signature of Sponsor

AMEND Senate Bill No. 839* House Bill No. 1244

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-2360, is amended by deleting the section and substituting the following:

(a)

(1) As used in this section, unless the context otherwise requires:

(A) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit;

(B) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit;

(C) "Classification of benefits" means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits; these classifications of benefits are the only classifications that may be used except that there may be sub-classifications within both outpatient classifications differentiating office visits from other outpatient items and services, including outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items;

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(D) "Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(E) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or any certificate issued under the policies, contracts, or plans;

(F) "Mental health or alcoholism or drug dependency benefits" means benefits for the treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

(G) "Non-quantitative treatment limitations," or "NQTLs," are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

(i) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(ii) Formulary design for prescription drugs;

(iii) Tier design for plans with multiple network tiers, including preferred providers and participating providers, and network tier design;

(iv) Standards for provider admission to participate in a network, including reimbursement rates;

(v) Plan methods for determining usual, customary, and reasonable charges;

(vi) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, that are also known as fail-first policies or step therapy protocols;

(vii) Exclusions based on failure to complete a course of treatment;

(viii) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(ix) In- and out-of-network geographic limitations;

(x) Standards for providing access to out-of-network providers;

(xi) Limitations on inpatient services for situations where the participant is a threat to self or others;

(xii) Exclusions for court-ordered and involuntary holds;

(xiii) Experimental treatment limitations;

(xiv) Service coding;

(xv) Exclusions for services provided by clinical social workers;

(xvi) Network adequacy; and

(xvii) Provider reimbursement rates, including rates of reimbursement for mental health and substance abuse services in primary care;

(H) "Predominant" means application to more than one-half (1/2) of such type of limit or requirement;

(I) "Substantially all" means application to at least two-thirds (2/3) of all medical or surgical benefits in a classification; and

(J) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(2) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits or alcoholism or drug dependency benefits, including, but not limited to, § 56-7-2601 and § 56-7-2602, any individual or group health benefit plan issued by any entity regulated pursuant to this title shall provide coverage for mental health or alcoholism or drug dependency services as required by this section. Nothing in this section shall be construed as a mandate that exceeds the essential health benefits requirements of 42 U.S.C § 18022(b).

(3) As to either aggregate lifetime limits or annual limits, or both, for a health benefit plan providing both medical and surgical benefits and mental health or alcoholism or drug dependency benefits:

(A) If the plan does not have a limit on substantially all medical and surgical benefits, the plan may not impose the limit on mental health or alcoholism or drug dependency benefits;

(B) If the plan has a limit on substantially all medical and surgical benefits, the plan shall either include mental health or alcoholism or drug dependency benefits under the limit applied to medical and surgical benefits, or apply a separate limit to mental health or alcoholism or drug dependency benefits that is no less than the one applied to medical and surgical benefits; and

(C) If the plan has varying limits on different medical or surgical benefits, the plan shall apply an average limit to mental health or alcoholism or drug dependency benefits with the average to be computed based on the weighted average of the varying limits.

(4) In the case of a health benefit plan that provides both medical and surgical benefits and mental health or alcoholism or drug dependency benefits, the plan shall ensure that:

(A) The financial requirements applicable to the mental health or alcoholism or drug dependency benefits in any classification of benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits in the same classification of benefits covered by the plan, and there are no separate cost sharing requirements that are applicable only with respect to mental

health or alcoholism or drug dependency benefits in any classification of benefits; and

(B) The quantitative treatment limitations applicable to such mental health or alcoholism or drug dependency benefits in any classification of benefits are no more restrictive than the predominant quantitative treatment limitations applied to substantially all medical and surgical benefits in the same classification of benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or alcoholism or drug dependency benefits in any classification of benefits.

(5) A health benefit plan may not impose a NQTL with respect to a mental health condition or alcoholism or drug dependency in any classification of benefits unless, under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or alcoholism or drug dependency benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(6) With respect to opioid use disorders, an insurer shall use policies and procedures for the election and placement of opioid use disorder treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of other drugs.

(7) An issuer of a plan may not count toward the number of outpatient visits required to be covered under subdivisions (a)(3) and (a)(4) an outpatient visit for the purpose of medication management, and shall cover that outpatient visit under the same terms and conditions as it covers outpatient visits for the

treatment of physical illness. Medication management shall not include services that could be billed as a therapy or consultation visit. For the purposes of this subdivision, "medication management" means pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

(8) A plan may not establish a separate limitation for mental health services for out-of-pocket cost sharing that is more costly than the limitation applied to medical and surgical benefits.

(b) Nothing in subsection (a) prohibits an employee health benefit plan, or a plan issuer offering an individual or group health plan from utilizing managed care practices for the delivery of benefits required under this section, provided that for any utilization review or benefit determination for the treatment of alcoholism or drug dependence the clinical review criteria is the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. No additional criteria may be used during utilization review or benefit determination for treatment of substance use disorders.

(c) The mandate to provide coverage for mental health services shall not apply with respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of the increase in cost shall be filed with the department after twelve (12) months of experience. If the commissioner determines that the increase in cost is a result of the requirements of this section, the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan that the plan does not have to comply with the mandate set out in this section. The issuer may appeal the letter as final agency action pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) The department of commerce and insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343), this section, § 56-7-2601, and § 56-7-2602, which includes:

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health benefit plans;

(3) Accepting, evaluating, and responding to complaints regarding such violations;

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or alcoholism or drug dependency coverage; provided, that individually identifiable information shall be excluded; and

(5) Beginning no later than January 1, 2018, and once every three (3) years subsequently, performing parity compliance market conduct examinations of individual and group health benefit plans, including, but not limited to, reviews of network adequacy, reimbursement rates, denials, and prior authorizations. Once it has been determined that substantial parity compliance is achieved, the parity compliance market conduct examinations shall occur once every five (5) years.

(e) Not later than January 31, 2019, the department shall issue a report to the general assembly and provide an educational presentation to the general assembly. The report and presentation shall:

(1) Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(2) Discuss the methodology the department uses to check for compliance with this section, § 56-7-2601, and § 56-7-2602;

(3) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws and summarize the results of such market conduct examinations. Individually identifiable information shall be excluded from the reports consistent with federal privacy protections. This discussion shall include:

(A) The number of market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations; and

(D) A summary of the basis for the final decision rendered in each market conduct examination;

(4) Detail any educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C § 18031(j), § 56-7-2601, and § 56-7-2602;

(5) Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and

(6) Describe how the department examines any provider or consumer complaints related to denials or restrictions to care for opioid use disorder treatment for possible violations of this section, the MHPAEA, 42 U.S.C §

18031(j), § 56-7-2601, and § 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone is approved; and

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine.

(f) The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and shall be made available to the public by posting the report on the department's website and by other means as the department finds appropriate.

(g) Benefits under this section may not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care and treatment of psychiatric, mental, or nervous disorders.

(h) Nothing in this section applies to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited benefit hospital insurance policies.

(i) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. The rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(j) The commissioner shall monitor aggregate health benefit plan claims denials for mental health or alcoholism or drug dependency benefits on the grounds of medical necessity. The commissioner shall examine denial rates for these benefits among inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drugs, and emergency care. The commissioner shall study and compare denial rates among the health benefit plans and shall request additional data if significant discrepancies in denial rates are found. These examinations shall occur no less frequently than once every three (3) years, commencing on January 1, 2018.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1018.

(a) Every health insurance carrier that issues a health benefit plan under the jurisdiction of the department of commerce and insurance must submit an annual report to the department on or before March 1 that contains the following information:

(1) The frequency with which the health insurance carrier required prior authorization for all prescribed procedures, services, or medications for mental health or alcoholism or drug dependency benefits during the previous calendar year and the frequency with which the health insurance carrier required prior authorization for all prescribed procedures, services, or medications for medical

and surgical benefits during the previous calendar year. Health insurance carriers must submit this information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits. The frequency shall be expressed as a percentage, with total prescribed procedures, services, or medications within each classification of benefits as the denominator and the overall number of times prior authorization was required for any prescribed procedures, services, or medications within each corresponding classification of benefits as the numerator;

(2) A description of the process used to develop or select the medical necessity criteria for mental health or alcoholism or drug dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(3) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health or alcoholism or drug dependency benefits and medical and surgical benefits;

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in subdivision (a)(2) and for each NQTL identified in subdivision (a)(3), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health or alcoholism or drug dependency benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(C) Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL as written for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes or strategies used to apply each NQTL in operation for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the health insurance carrier that the results of the analyses above indicate that the insurer or entity is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub .L. No. 110-343), and its implementing regulations, including 45 CFR 146.136 and any other applicable regulations;

(5) The rates of and reasons for denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network,

prescription drugs, and emergency care mental health or alcoholism or drug dependency services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year;

(6) A certification signed by the health insurance carrier's chief executive officer and chief medical officer that affirms that the health insurance carrier has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with the necessary provisions of this section, § 56-7-2601, § 56-7-2602, and the MHPAEA; and

(7) Any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be "proprietary" or have "commercial value." Any information submitted that is proprietary shall not be made a public record under title 10, chapter 7.

(b) The commissioner shall not certify any health benefit plan of a health insurance carrier that fails to submit all data as required by this section.

(c) Separate NQTLs that apply to mental health or alcohol or drug dependency benefits but do not apply to medical and surgical benefits within any classification of benefits are not permitted.

(d) For the purposes of this section, "health insurance carrier" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services.

SECTION 3. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) Every managed care organization that participates in the TennCare program shall submit an annual report to the bureau of TennCare on or before March 1 of each year that contains the following information for enrollees in the TennCare program:

(1) The frequency with which the managed care organization required prior authorization for all prescribed procedures, services, or medications for mental health or alcoholism or drug dependency benefits during the previous calendar year and the frequency with which the managed care organization required prior authorization for all prescribed procedures, services, or medications for medical and surgical benefits during the previous calendar year. Managed care organizations must submit this information separately for inpatient benefits, outpatient benefits, emergency care benefits, and prescription drug benefits. Frequency shall be expressed as a percentage, with total prescribed procedures, services, or medications within each classification of benefits as the denominator and the overall number of times prior authorization was required for any prescribed procedures, services, or medications within each corresponding classification of benefits as the numerator;

(2) A description of the process used to develop or select the medical necessity criteria for mental health or alcoholism or drug dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(3) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health or alcoholism or drug dependency benefits and medical and surgical benefits. There may be no separate NQTLs that apply to mental health or alcohol or drug dependency benefits but do not apply to medical and surgical benefits within any classification of benefits;

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in subdivision (a)(2) and for each NQTL identified in subdivision (a)(3), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health or alcoholism or drug dependency benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

(C) Identify and describe methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL as written for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes and strategies used to design each NQTL as written for medical and surgical benefits;

(D) Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL in operation for mental health or alcoholism or drug dependency benefits are comparable to, and no more stringent than, the processes or strategies used to apply each NQTL in operation for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the managed care organization demonstrating that the results of the analyses required by this subdivision (a)(4) indicate that the insurer or entity is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. No. 110-343), and its implementing regulations, which include 42 CFR 438.900, 42 CFR 438.905, 42 CFR 438.910, 42 CFR 438.915, 42 CFR 438.920, and 42 CFR 438.930 and any other applicable regulations;

(5) The rates of and reasons for denial of claims for inpatient, outpatient, prescription drugs, and emergency care mental health or alcoholism or drug dependency services during the previous calendar year compared to the rates of, and reasons for, denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year; and

(6) A certification signed by the managed care organization's chief executive officer and chief medical officer that affirms that the managed care organization has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with this section and the MHPAEA.

(b) The bureau of TennCare shall monitor managed care organization claims denials for mental health or alcoholism or drug dependency benefits on the grounds of medical necessity within each classification of benefits among inpatient benefits, outpatient benefits, prescription drugs, and emergency care. The bureau of TennCare shall study and compare denial rates among each managed care organization and shall request additional data if significant discrepancies in denial rates are found.

SECTION 4. This act shall take effect January 1, 2018, the public welfare requiring it.

This act shall apply to policies and contracts entered into or renewed on and after January 1, 2018.